UB | MD ORTHOPAEDICS & SPORTS MEDICINE

Patient Medical History Update

Last Name:________________________ First Name: ________________________________ MI: _______ Today's Date: ______________

DOB:_________________ Age:____________ Height: ________________ Weight: _________________

ALLERGIES: ☐**None** ☐Penicillin ☐Sulfa ☐Aspirin ☐Nickel ☐Dye ☐Codeine ☐Latex ☐Iodine ☐Egg ☐Shellfish ☐Pollen

☐Other Allergies Not Listed:____

MEDICATIONS: List medications (*including over the counter medications, such as vitamins, Tylenol, etc.)* Please provide a typed medication list if necessary or use reverse side.

Drug	Dosage	How Taken *(with meals, as needed, etc)*	Reason

Have you had any changes in your medical history (Major illnesses, surgery/operations, hospitalizations, current ongoing illness - e.g. diabetes) since your last appointment? ☐No ☐Yes - If yes, please describe: ____

Have you received an influenza vaccine/flu shot within the past 12 months?☐No ☐Yes - if yes, Date: ____________________________

Smoking: ☐ Never ☐ Former ☐ Current Smoker: Every Day ☐ Current Smoker: Some Days

PRESENTING PROBLEM

Have you had a new injury since your last appointment? ☐No ☐Yes

Why are you seeing the doctor today?

Shoulder ☐Right ☐ Left **Elbow** ☐Right ☐ Left **Wrist** ☐Right ☐ Left **Hand** ☐Right ☐ Left **Hip** ☐Right ☐ Left

Leg ☐Right ☐ Left **Knee** ☐Right ☐ Left **Ankle** ☐Right ☐ Left **Foot** ☐Right ☐ Left **Neck** ☐ **Back/Spine** ☐ **Concussion** ☐

My injury is: ☐ **Work Related** from _/___/______ ☐ **Due to a Car Accident** from _/___/_______ ☐ Sports Injury from _/_______/_______

☐ Other Injury from ____________/___/______ ☐ No Known Specific Injury/Onset was: ☐Gradual ☐Sudden

*Please specify how your injury occurred:*____

____

In your own words, please describe your chief complaint: ____

____

Have you had any diagnostic studies other than routine x-rays? ☐ No ☐ Yes - If yes, where was the study performed: __________________

If yes, what type: ☐MRI ☐CT ☐Bone Scan ☐Ultrasound ☐EMG ☐Other: ____________________________

What other doctors have you seen for your current problem? (e.g. chiropractor) ____

Have you done any formal physical therapy for your current problem? ☐No ☐Yes - If yes, for how long:___________________________

Have you had surgery for this current problem? ☐No ☐Yes - If yes, when:____

Have you missed work as a result of this problem? ☐No ☐Yes - If yes, when: ____

Occupation: ____________________________________ **Employer:**____

Current Work Status: ☐ Full Time ☐ Part Time ☐Not Working due to this injury ☐Not Working for other reasons
☐ Working with restrictions ☐ Disabled ☐ Unemployed ☐ Retired

The information on this form has been completed accurately to the best of my knowledge. I understand it is my responsibility to inform the doctor's office of any change in my information.

_______________________________________ _______________________________________ Date:_______________

Print Name of Patient or Parent/Legal Guardian (if patient is under 18 years of age) — Signature

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